NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Bluebonnet Haus	RC-1253	641 Rimview	208-734-4445
Administrator	City	Zip Code	Survey Date
Betty Bennett	Twin Falls	83301	12/11/2023
Survey Team Leader	Survey Type		Response Due
Brown, Stacey	Health Care Licensure and Follow-Up + complaint investigation		01/10/2024

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	One of five employees, whose personnel records were reviewed, did not have a Department Criminal History and Background Check completed. This caregiver had worked several shifts alone, without a background check, since they were hired on 10/28/23. Upon interview with the administrator, it was confirmed the Department Criminal History and Background Check had not been completed. ***Previously cited on 4/12/22***
2	.215.08.f. Notification to Licensing Agency within One Business Day.	The facility did not notify Licensing and Certification (L&C) within one business day when Resident #4 had an airway obstruction after lunch on 7/20/23 and required assessment and treatment at the hospital. Resident #6 fell on 3/24/23 and was transported to the Emergency Department for further evaluation. The administrator stated she was not aware these incidents needed to be reported to L&C.
3	.305.02.a. Quarterly Nursing Assessments.	Residents' Medication Administration Records (MARs) did not consistently match the medication labels and the medication orders. For example, Resident #1 was ordered to receive one spray of fluticasone into each nostril twice daily, but the medication label documented the resident was to receive two sprays into each nostril once daily. Also, there was an order for

		Resident #1 to receive 17 grams of Miralax once daily as needed, but the MAR documented the resident was to receive 17 grams every other day on a scheduled basis. Resident #1 had an order for Maalox 10-20 ml before meals as needed, but the MAR documented the resident was to receive 20 cc of this antacid twice daily as needed. The Maalox label documented Resident #1 was to receive 10 ml four times daily as needed. Resident #3 was ordered to receive Naproxen 200 mg, two tabs every 6 hours as needed. However, the Naproxen label documented the medication strength was 250 mg and instructed staff to give 1 tablet every 6 hours as needed. The facility administrator, who was also the facility nurse, stated at one point, she became aware the residents' MARs, medication labels and orders did not match, and she had been working on resolving this issue.
4	.305.02.b. Quarterly Nursing Assessments.	Residents did not consistently receive their medications as ordered. For example, on 4/10/23, Resident #1 was ordered to receive 8 units of insulin every evening, but since at least October 2023, the resident had been receiving the insulin in the morning. Resident #1 was ordered to receive 20 mg of escitalopram daily as of 4/10/23, but as of the time of the survey, the resident was being given 10 mg of escitalopram daily. Also, Resident #1 was ordered to have 50 mg of hydroxyzine every 4-6 hours as needed for anxiety, but the resident had been receiving this medication twice daily on a scheduled basis since October 2023. On 9/6/23, Resident #4 was ordered to receive mupirocin 2% ointment twice daily, but this was never added to the resident's MAR and the resident did not receive this medication. The facility administrator, who was also the facility nurse, stated she was not aware the residents had not been consistently receiving their medications as ordered.
5	.305.02.c. Current Medication Orders and Treatment Orders.	The facility did not have current, signed orders in five of seven sampled residents' records. For example, Resident #1 was

		taking Trulicity, as-needed olanzapine and vitamin D, but there were no orders for these medications in the resident's chart. Resident #2's order for lisinopril was not in their record. Resident #3's record did not include the orders for rizatriptan, Tums, and earache drops. The facility administrator, who was also the facility nurse, stated she was not aware these orders were not in the residents' records.
6	.310.01.a. Medication Distribution.	Between 12/7/23 to 12/8/23, residents' medications, including insulin, were observed unsecured in the medication refrigerator located in one of the halls of the facility. The administrator stated she had forgotten to order a lock for the medication refrigerator.
7	.310.01.c. Medication Distribution.	The facility did not consistently maintain the medication refrigerator temperatures between 38 and 45 degrees F, with temperatures as low as 30 degrees F. The medication refrigerator, which contained residents' insulin and other medications, was out of temperature range or not documented 21 times in October 2023, 20 times in November 2023, and 3 times between 12/1/23 and 12/6/23, with no corrective action taken. The facility nurse/administrator stated she was unaware the temperatures had been out of range or not recorded. ***Previously cited on 4/12/22***
8	.310.01.g. Medication Distribution System.	The facility did not ensure all ordered, as-needed (PRN) medications were available. For example, Resident #1 did not have their ordered Tums and guaifenesin available. Resident #3 did not have their ordered acetaminophen, ibuprofen, docusate sodium, Milk of Magnesia, triamcinolone cream and Tums available to them in the medication cart. The facility nurse/administrator stated she was unaware these PRNs were not available, but the residents had not recently needed these medications.
9	.310.02.f. Discontinued and Expired Prescriptions.	Four of four medication destruction logs reviewed did not include a witness signature for the destruction of non-narcotic medications. The administrator stated she believed only the

		destruction log for narcotic medications required two signatures.
10	.310.04.e. Psychotropic or Behavior Modifying Medication.	Two of two residents, who required six-month psychotropic medication reviews, did not have these completed. For example, Resident #1 was taking olanzapine, escitalopram, divalproex, Invega, and hydroxyzine, and there had been no psychotropic medication review completed since April 2023. In addition, there were no behavioral updates included in the April 2023 review. Resident #2 was taking Effexor, quetiapine and trazodone, and there were no six-month psychotropic medication reviews completed. The facility nurse/administrator confirmed there were no current psychotropic medication reviews for these residents.
11	.320. NEGOTIATED SERVICE AGREEMENT (NSA) REQUIREMENTS.	Three of three residents whose records were reviewed did not have a completed interim care plan to direct staff on the residents' cares when they were first admitted to the facility. The administrator stated she was not aware she was required to complete an interim plan of care.
12	.330.04. Behavior Documentation.	The facility did not ensure residents' records were current and complete. For example, the facility's caregivers documented unusual events concerning residents in a spiral notebook. There were entries made on multiple residents on each page of the notebook, so these notes could not be added to each resident's record. Also, the majority of these caregiver notes were unsigned and many were undated. In addition, there was other documentation missing from the residents' charts, such as change of condition assessments for Residents #1 and #3 for multiple dates, as well as hospice notes for Resident #4. The facility nurse/administrator stated she had completed those assessments including the documentation, but she could not locate the documentation, nor could she locate the hospice notes for Resident #4. The nurse/administrator stated she believed a previous, disgruntled employee had removed the documentation from the residents' records when they were

		terminated.
13	.330.13. Personnel Records.	The facility did not maintain staff records with all required documentation. For example, two employees, hired since the last survey, had completed the 16 hours of orientation, but there was no documentation of the 16 hours in their employee files. Three staff members' files did not contain documentation of eight hours of annual continuing education, and these employees had worked at the facility greater than one year. One of the caregivers, who worked alone and was CPR/1st aid certified, but this CPR/1st aid card was missing from their file. One medication technician had taken the medication certification course years prior to their employment at this facility, but the employee could not find this card to include in their file. Another employee, who had been hired at the facility on 7/14/23, had a cleared Criminal History Background Check, but a copy of this report was not in their file, only a screenshot from the background check unit website showing they had been cleared to work. The nurse/administrator stated these employees had all received the orientation training, continuing education, CPR/1st aid certification and their Criminal History Background Check, but she was unsure why the documentation of these items had not been retained in the staff members' files.
14	.330.14. As Worked Schedules.	The facility's as-worked schedules did not document the actual times all staff members were at the facility. Also, the schedule did not include the last names of all staff members. The administrator stated she was not able to show actual times staff members worked.